FINAL EVALUATION OF THE BI-DIRECTIONAL REFERRAL SYSTEM REPORT

KHOMAS, KAVANGO, OSHIKOTO AND OSHANA REGIONS

Dates of the final evaluation: July 25-August 10, 2012

Table of Content

Acronyms/Abbreviations

BD	Bi-Directional
CDC	Communicable Disease Clinic,
CAA	Catholic AIDS Action
CHBC	Community and Home **B**ased Care Organizations
DSP	Directorate of Special Programmes
HC	Health Centers
TCE	Total Control of Epidemic
PHC	Primary Health Care
MSH	Management Sciences for Health

1. Executive Summary

The Ministry of Health and Social Services has put mechanism in place to ensure functioning referral system between the 3 levels of health care service delivery in public sectors. Also, a standard referral form for Community and Home Based Care Providers was developed and impendent in the National Community Health Based Standard 2010. Despite the effort made to ensure proper referral system, the existing referral system is faced with problems such as the lack of standard referral procedure and poor communication among health care providers at all level. Poor feedback was evidenced by the palliative care situational analysis 2008.

In this context, the MoHSS and IntraHealth have developed standardized referral tools derived from existing referral tools. Four regions (Khomas, Oshana, Oshikoto and Kavango) were purposely selected to pilot the bi-directional referral system from December 2011 to June 2012. A baseline assessment was conducted in February 2012; whist the planned mid-term evaluation could not materialize due to competing priorities. Thus, the final evaluation was conducted in July-August 2012.

The aim of the final evaluation was to: (1) assess the availability and the use of the bi-directional referral tools; (2) evaluate, completeness and accuracy of the bi-directional referral forms; (3) assess the availability of a referral focal person (4) evaluate the platform for data review and whether identifies challenges were addressed and (5) get health care providers opinions about the usefulness of the bi-directional referral system

1.1 General Findings

The assessment showed that the bi-directional referral system is being implemented by most piloting facilities. It was also found that there were few facilities that demonstrated the effective use of bi-directional referral system despite the challenges experienced during the piloting phase. Okuyu-kamasheshe, Uukwiyuushona and Oshakati PHC in Oshana region, Ontanga and Oshigambo in Oshikoto region, VCT Rundu in Kavango region and Dordabis clinic in Khomas used the referral system efficiently and effectively and are considered as centers of excellence.

1.1.1 Availability and use of the bi-directional referral tools

The bi-directional referral form books and Registers were available and are being utilized in all piloting facilities visited in Khomas, Oshana and Oshikoto regions. While the same referral tools were only available and utilized in 50% of facilities visited in Kavango. Referral guidelines were not available in some visited facilities, and this is also an indicator tha guidelines were under-utilized.

1.1.2 Completeness and accuracy use of the bi-directional referral tools

Most facilities (83%) visited used the bi-directional referral forms of which 54% used them accurately, while 71% of facilities visited used the referral registers of which 18 % used them accurately. The completion and accuracy of referral registers were hampered by poor feedback and tracking system that left most registers with open spaces.

1.1.3 Availability of an active designated referral focal person

The referral focal person is required in the bi-directional referral system, to ensure smooth functioning of the referral network. This person will be amongst others be responsible for tracking of patients, compilation of the referral report and ensure that the referring facilities have received the feedback. It was found that only 38% of facilities visited were having a referral focal person in place. Referral system was successfully implemented in facilities with referral focal person.

1.1.4 Existence of platform for data review

Referral committee that should be integrated in any suitable existing facility committees is required to review referral report, record successes and identify possible challenges that may hamper the effective use of bi-directional referral system and act upon them. The assessment found 37% of health facilities are having platforms to review referral data on a regular basis.

1.2 Challenges

Limited supply of bi-directional referral tools, leads to disruption of continuous referral services as some facilities run out of referral tools which resulted to few facilities developing self-made registers to record the referrals

It was also noted that some health care providers who attended the clinical orientation workshops did not give feedback and orientation to their colleagues, leading to under-utilization and inaccuracy of the bi-directional referral tools.

The lack of a focal person in some facilities led to poor tracking of the bi-directional referral system. Most facilities report the lack of phones and cellphones/airtime to ease communication for follow-up purposes

1.3. Recommendations

There is a need to incorporate the consolidated bi-directional referral tools into the Ministry stationary ordering system, to ensure continuous supply of the referral tools and sustainability

The MoHSS and IntraHealth should ensure that all health care workers are trained towards the use of the bi-directional; referral system

The MoHSS and developing partners should introduce the SMS system to ensure smooth tracking of patients.

In addition, the Regions should procure fax machines for all health facilities and external telephone line to ensure proper communication amongst health care providers

2. Background

Referral network exist between and within the three levels of health care service delivery namely; PHC Clinics, District Hospitals, Referral Hospitals and Community Home Based Care Organizations (CHBC). Although, the referral system exists, studies revealed lack of consistent feedback and tracking of clients/patients to ensure that clients/patients have reached destination and benefited from appropriate services. It was also reported that quite a number of patients where lost to follow-up after transferred out to other facilities (MSH, 2010).

The existing referral system is also faced with lack of standard referral procedures, poor communication and inconsistent Follow-up and feedback between facilities/organizations (Palliative Care Situation Analysis, 2009).

To address this gap, the Directorate of Special Programme (DSP) in collaboration with IntraHealth and other relevant stakeholders developed a standardized bi-directional referral network tools with the aim to strengthen collaborations, amongst health care providers at all levels, and most importantly to increase linkages and retention to treatment, care and support services to ensure continuum of care.

Although the bi-directional referral tools were derived from the existing referral forms and data collection tools, there was still a need to test its effectiveness and efficiency prior to the dissemination of the materials to all health care providers. In light of the above mentioned, four regions (Khomas, Kavango, Oshikoto and Oshana) were selected to pilot the bi-directional referral system.

The orientation workshops were conducted between October and December 2011. All health facilities in piloting regions were targeted for the orientation workshops, however some facilities were unable to send representative due to amongst others; shortage of personnel and distance to the workshop venue. Twenty-five out of 58 (25/58) public health facilities in Kavango, 24/24 public health facilities in Oshikoto, 15/17 public health facilities in Oshana and 9/12 public health facilities in Khomas were orientated toward the utilization of the referral network tools.

Community and Home Based Care Organizations (CHBC) amongst others; Catholic AIDS Action (CAA), Life Line Child Line and Total Control of Epidemic (TCE) were also oriented and form part of the piloting team.

A baseline assessment was conducted in February 2012, aiming at checking the availability, effective and efficient use of the bi-directional referral system tools. The final evaluation of the pilot in the four selected regions was conducted from July 25 to August 10, 2012.

3. PURPOSE AND SPECIFIC OBJECTIVES

3.1 Purpose

The purpose of the final evaluation was to systematically examine the effectiveness of the referral system in the four pilot regions in order to identify accomplishments/successes, challenges/gaps and develop an action plan before the roll out of the system.

3.2 Specific Objectives

- To check the availability and the use of the bi-directional referral tools
- To assess the use, completeness and accuracy of the bi-directional referral forms, registers and monthly summary report forms
- To check the availability of an active designated focal person
- To ask the existence of a platform for data review that identifies successes, gaps and act upon them

4. Methods

4.1 Sampling

All piloting facilities were targeted and any health care worker on duty qualified for interview as it is expected from all of them to know and utilize the bi-directional referral system.

4.2 Data collection tool

A standardized interviewer administered questionnaire was used to collect the data. In addition, the following methods were used:

Interviews: One-on-one interviews were conducted with staff found in the facilities visited for clarity on issues that needed clarifications

Inspections: Inspections were done to determine whether the bi-directional referral tools were accurately used and where necessary provide onsite orientations.

4.3. Data Analysis

Scoring system: two standards were used and each had 5 criteria. Each criterion was rated as follow: 0=No, the criteria were not met, 1=Yes, some of the elements are in place, but the criterion is not fully satisfied and 2=Yes, the criterion is fully met.

The data were captured in Microsoft excel for analysis. The results are presented using descriptive statistics that include percentages and the information was shown in bar charts.

5. Limitations

The baseline assessment was conducted in most selected piloting facilities. Moreover, the planned mid-term evaluation in May 2012 could not materialize due to competing priorities. The monitoring assessments were meant to identify gaps during the pilot phase and act upon them to ensure effective implementation of the bi-directional referral system. Some gaps found during the final evaluation could be rectified during the missed pre-assessments. The monthly summary forms were developed during the baseline assessment leading to only few facilities in Oshikoto and oshana receiving the tools. Thus, this part was omitted from the evaluation.

6. Key Findings

The accomplishments/successes, challenges/gaps and Recommendations were based on the specific objectives per region piloted.

6.1 Availability and the use of the bi-directional referral tools

All facilities visited in Khomas, Oshana and Oshikoto regions are using the bi-directional referral tools, whilst 7 (50%) facilities (Rundu CDC, Rundu New Start, Andara Hospital, Nyangana hospital, Sauyemwa clinic, Tondoro HC and Katere clinic) in Kavango are using the referral tools.

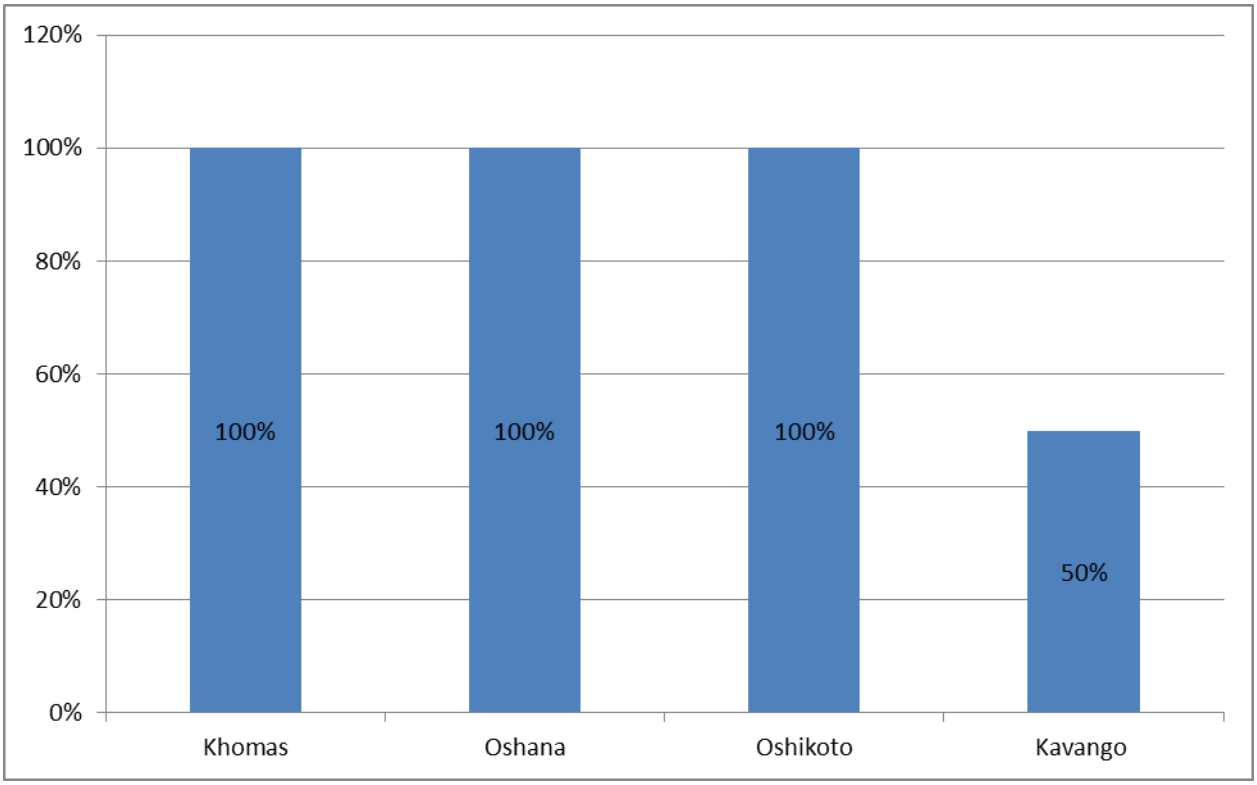

Figure 1: Availability and use of bi-directional referral tools

6.2 Availability of Referral Guidelines

All (100%) facilities visited in Khomas, 6 (37.5%) facilities (Uukwiyu-Uushona, Oshakati HC, Ehafo clinic, Ekamba clinicEheke clinic and Omutayi clinic) in Oshana, 11 (65%) facilities (Oshingambo clinic, Ontananga clinic, Olukonda clinic, Lombardt clinic, Omuthiya clinic, Shanamutango clinic, Farm Scott clinic, Okankolo clinic, Onyulae clinic, Onamishu clinic, and Onkumbula clinic) and 9 (64%) facilities (Rundu clinic, Rundu CDC, Rundu New Start, Andara hospital, Nyangana hospital, Sauyemwa clinic, Tondoro HC, Katere clinic and Mabushe clinic) in Kavango region are keeping the referral guidelines.

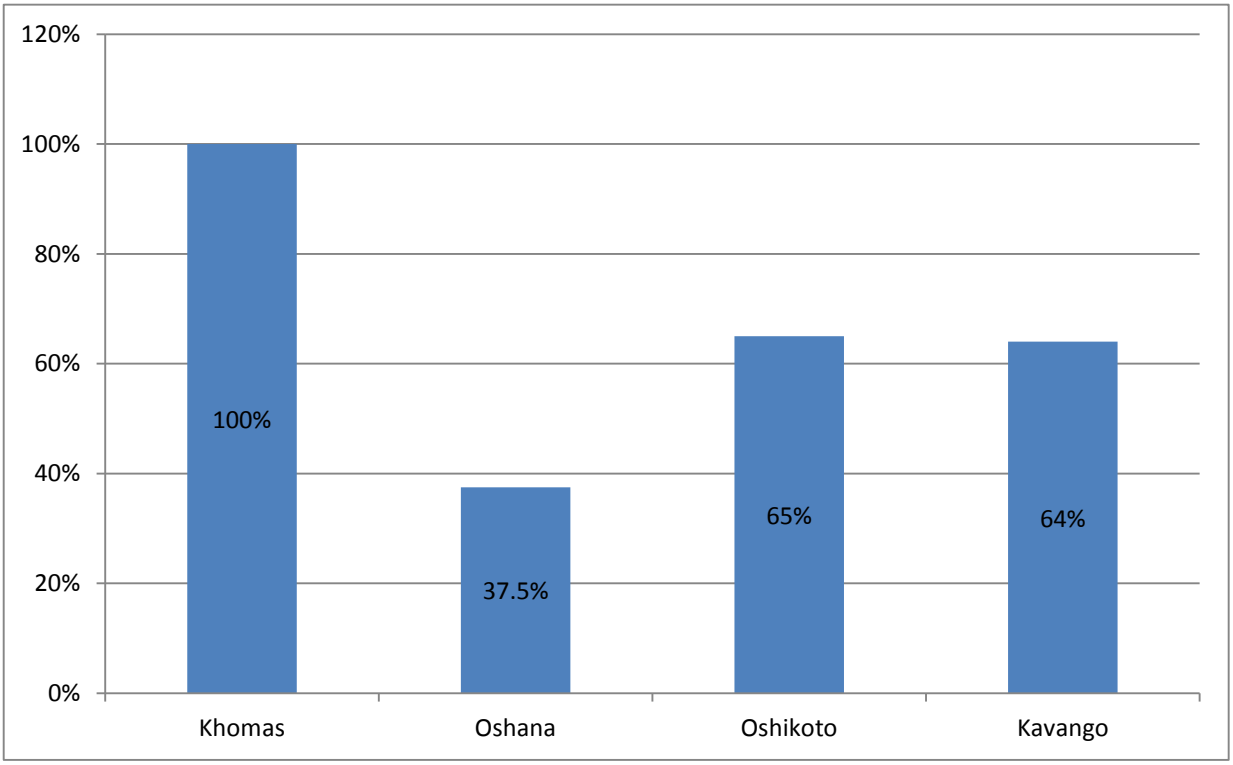

Figure 2: Availability of referral guidelines

6.3 Use, completeness and accuracy of the bi-directional referral forms

All facilities in Khomas are using the bi-directional referral forms, of which five (62.5%) facilities (Katutura Hospital ANC, Dordabis Clinic, Okuryangava Clinic, Robert Mugabe Clinic, and Katutura HC/VCT) are accurately completing the referral forms.

In Oshana, all facilities are using the referral forms, of which 9 (56%) facilities/organization(Ondangwa HC, Eheke clinic, Ou Nick Health Centre (HC), Ekamba clinic, Okau-Kamasheshe, Okaku clinic, Uukwiyu-Uushona, Ompundja clinic and Enkono clinic)) are accurately completing the referral forms.

Furthermore, in Oshikoto region, 14 (82%) facilities (Oshigambo, Tsumeb, Ontananga, Lombardt, Olukonda, Onkumbula, Onayena, Ndamona, Omuthiya, Shanamutango, Farm Scott, Okankolo, Onyuulae and Onamishu) use referral forms and 9 (53%) facilities (Oshigambo, Olukonda, Onayena, Lombardt, Ndamona, Tsumeb, Okankolo, Onamishu and Onkumbula) accurately completed the referral forms.

In Kavango region, 7(50%) facilities/organization (Rundu CDC, Rundu New Start, Andara Hospital, Nyangana Hopsital, Sauyemwa Clinic, Tondoro H/C and Katere Clinic) are using the referral forms of which all 3 (43%) facilities (Rundu CDC, Nyangana hospital, Sawyemwa clinic) are using accurately the referral forms

6.4 Use, completeness and accuracy of the referral registers

In **Khomas region**, 7 (87.5%) facilities (Katutura CDC, Katutura Hospital ANC, Dordabis Clinic, Okuryangava Clinic, Robert Mugabe Clinic, Khomasdal Clinic and Otjomuise clinic) are using the referral registers. One (12.5%) facility (Katutura HC) is accurately completing the referral register.

In **Oshana region**, all (100%) health facilities are using referral registers. However, one CHBC-TCE was not using the referral register yet and 5 (31%) facilities/organization (Eheke clinic, Ondangwa HC, Uukuyu-Uushona, Ekamba clinic and Okau-Kamasheshe clinic are using accurately the referral registers.

In **Oshikoto region**, 10 (59%) facilities (Oshigambo, Ontananga, Olukonda, Onayena, Omuthiya, Shanamutango, Tsumeb, Okankolo, Onyuulae and Onamishu) make use of referral register and 2 (12%) facilities (Oshigambo, Ontananga and Olukonda) are accurately completing the referral registers.

In **Kavango region**, 6 (43%) facilities (Rundu CDC, Rundu New Start, Andara Hospital, Nyangana Hopsital, Sauyemwa Clinic and Katere Clinic) are using the referral registers of which only 1 (17%) facility (VCT Rundu hospital) is accurately using the referral register

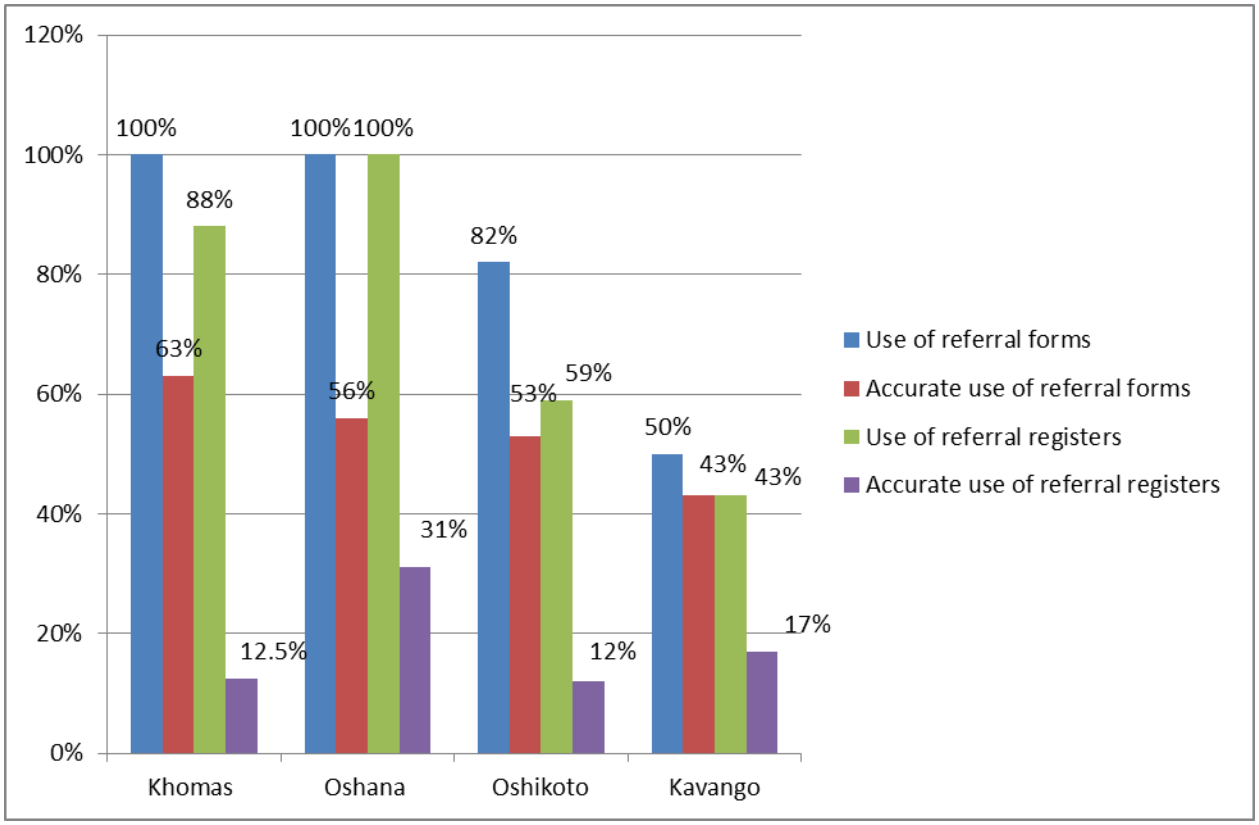

Figure3: use, completeness and accuracy of the bi-directional referral forms and registers

6.5 Availability of a referral focal person

In Khomas region, 4 (50%) facilities (Katutura hospital ANC, Dordabis clinic, Robert Mugabe clinic and Katutura HC/VCT) are having a referral focal person.

In Oshana region, 8 (50%) facilities (TCE, Ondangwa HC, Okatana HC, Okau-kamasheshe, Ongwediva HC, Uukwiyu-Uushona, Oshakati HC and Ehafo clinic) are having a referral focal person.

In Oshikoto region, 7 (41%) facilities (Oshigambo clinic, Ontananga clinic, Olukonda clinic, Ndamona, Tsumeb, Onyuulae clinic and Onkumbula) have a referral focal person.

In Kavango region, 4 (28%) facilities (Rundu CDC, Rundu New Start, Andara Hospital and Katere clinic) have a referral focal person (figure 4).

6.6 Availability of a platform for data review that identifies successes, gaps and act upon them

In Khomas region, 4 (50%) facilities (Katutura Hospital ANC, Dordabis Clinic, Robert Mugabe Clinic and Khomasdal clinic) are having a platform for data review, of which two (25%) facilities (katutura CDC and Robert Mugabe clinic) are using data to identify gaps and plan interventions and use data to take action.

In Oshana region, 9 (56%) facilities/organization (TCE, Ondangwa HC, Okatana HC, Okau-Kamasheshe clinic,Onamuthayi clinic, Ongwediva HC, Uukwiyu-Uushona, Oshakati HC and Ehafo clinic) are having a platform for data review, of which 8 (50%) facilities/organization (TCE, Ondangwa HC, Okatana HC, Okau-Kamasheshe, Ongwediva HC, Uukwiyu-Uushona, Oshakati HC and Ehafo clinic) used data to identify gaps and planned interventions and 7 (44%)facilities/organization (TCE, Okatana HC, Okau-Kamasheseh, Ongwediva HC, Uukwiyu-Uushona, Oshakati HC and Ehafo clinic) took action based on data review.

In Oshikoto region, 5 (29%) facilities (Oshigambo, Ontananga, Olukonda, Onyaanya and Onyuulae) have a platform for data review, of which 4 (24%) facilities (Oshigambo, Ontananga, Olukonda and Onyuulae) use data to identify gaps and plan for interventions and 4 (24%) facilities (Oshigambo, Ontananga, Shanamutango and Onyuulae) took action based on reviewed data.

In Kavango region, 2 (14%) facilities/organization (Rundu New Start, Andara Hospital) are having a platform for data review, used data to identify gaps and planned interventions and took action based on data review (figure 4).

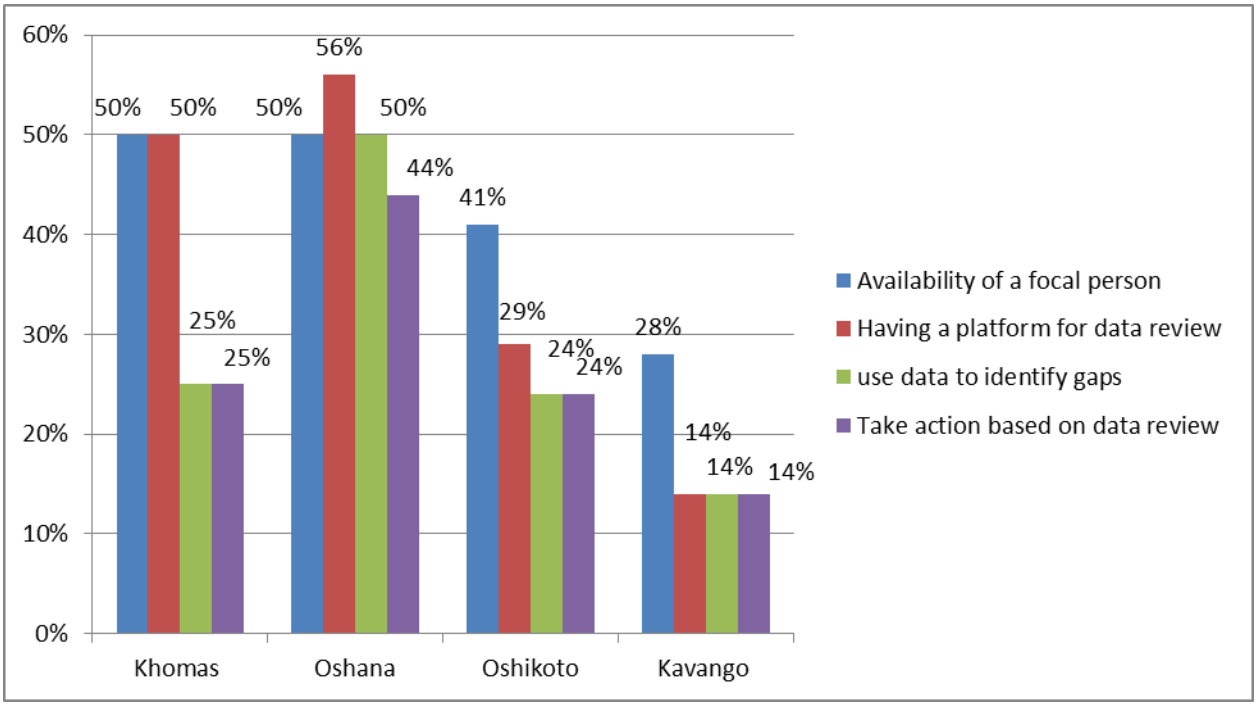

Figure 4: Availability of a referral focal person, platform for data review and actions based on identified gaps.

7. Regions performance

7.1 Khomas region

All (100%) facilities in Khomas are using the B-D tools and all are keeping the referral guidelines.

All facilities are using the referral forms, of which 5 (62.5%) facilities (Katutura Hospital ANC, Dordabis Clinic, Okuryangava Clinic, Robert Mugabe Clinic, and Katutura HC/VCT) are accurately completing the referral forms

Seven (87.5%) facilities (Katutura CDC, Katutura Hospital ANC, Dordabis Clinic, Okuryangava Clinic, Robert Mugabe Clinic, Khomasdal Clinic and Otjomuise clinic) are using the referral registers and one (12.5%) facility (Katutura HC) is accurately completing the referral register.

Four (50%) facilities (Katutura Hospital ANC, Dordabis Clinic, Robert Mugabe Clinic and Katutura CDC are having a focal person, 4 (50%) facilities (Katutura Hospital ANC, Dordabis Clinic, Robert Mugabe Clinic and Khomasdal clinic) are having a platform for data review and 2 (25%) facilities (katutura CDC and Robert Mugabe clinic) are using data to identify gaps and plan interventions and use data to take action.

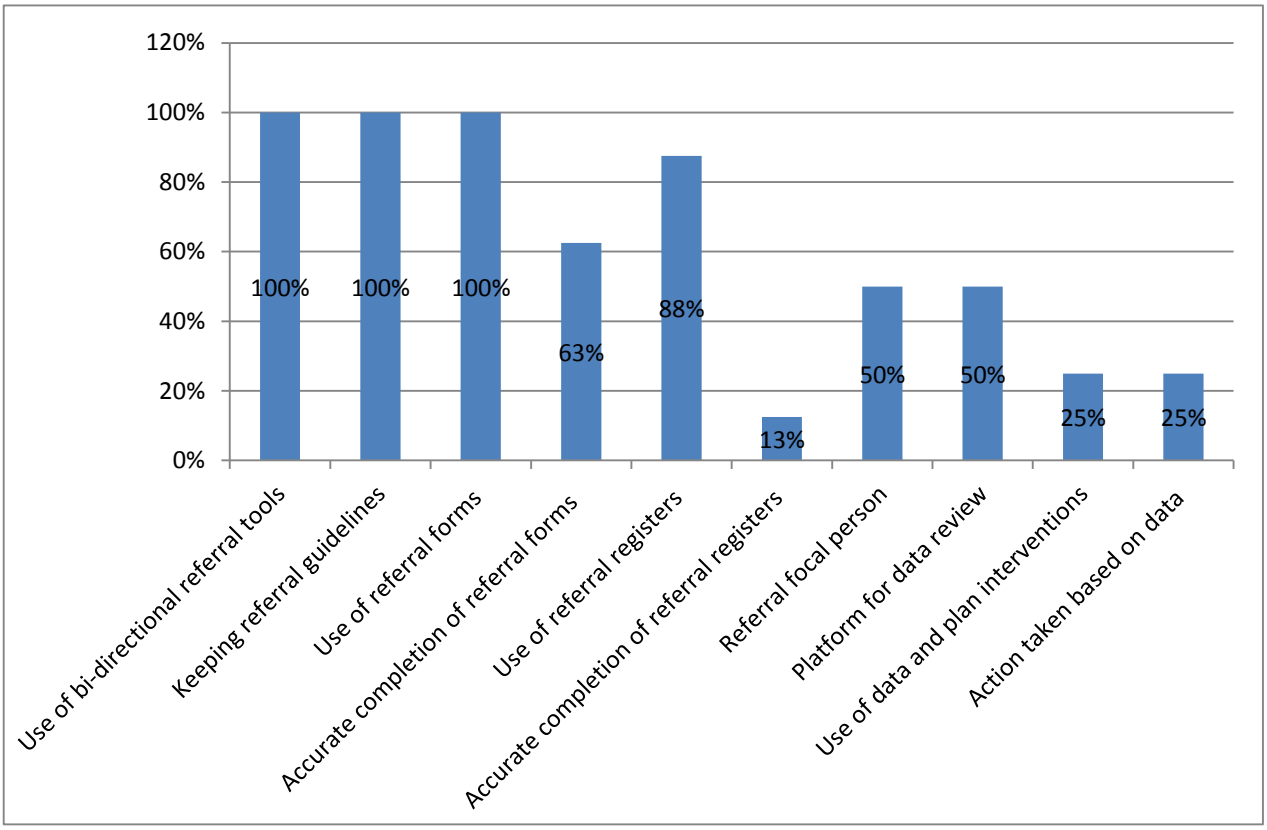

Figure 5: Khomas region performance

7.2 Oshana region

All (100%) facilities/organization use the B-D referral system tools and 6 (38%) facilities /organization (Eheke clinic, Ekamba clinic, Onamuthayi clinic, Uukwiyu-Uushona, Oshakati HC and Ehafo clinic) are keeping referral guidelines

All (100%) facilities/organization are using referral forms, of which 9 (56%) facilities/organization (Ondangwa HC, Eheke clinic, Ou Nick HC, Ekamba clinic, Okau-Kamasheshe, Okaku clinic, Uukwiyu-Uushona, Ompundja clinic and Enkono clinic)) are accurately completing the referral forms

Fifteen (94%) facilities/organization are using referral registers, but only one COBO-TCE was not using the referral register yet and 5 (31%) facilities/organization (Eheke clinic, Ondangwa HC, Uukuyu-Uushona, Ekamba clinic and Okau-Kamasheshe clinic are using accurately the referral registers

Eight (50%) facilities/organization (TCE, Okatana HC, Okau-Kamasheshe, Onamuthayi clinic, Ongwediva HC, Uukwiyu-Uushona, Oshakati HC and Ehafo clinic) are having a referral focal person. Nine (56%) facilities/organization (TCE, Ondangwa HC, Okatana HC, Okau-Kamasheshe clinic,Onamuthayi clinic, Ongwediva HC, Uukwiyu-Uushona, Oshakati HC and Ehafo clinic) are having a platform for data review and 8 (50%) facilities/organization (TCE, Ondangwa HC, Okatana HC, Okau-Kamasheshe, Ongwediva HC, Uukwiyu-Uushona, Oshakati HC and Ehafo clinic) used data to identify gaps and planned interventions while Seven (44%)facilities/organization (TCE, Okatana HC, Okau-Kamasheshe, Ongwediva HC, Uukwiyu-Uushona, Oshakati HC and Ehafo clinic) took action based on data review

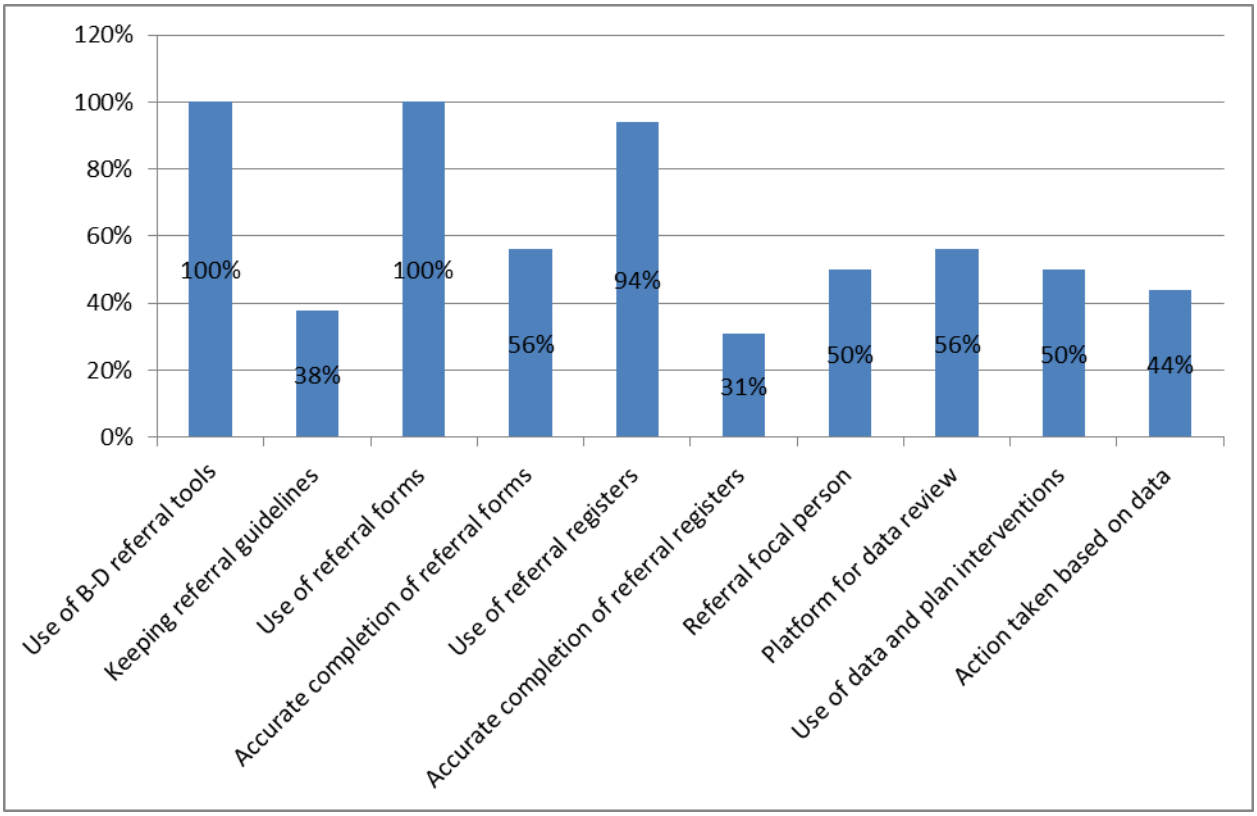

Figure 6: Oshana region performance

7.3 Oshikoto region

Sixteen Clinics (91%) use the B-D referral tools, except Tsintsabis Clinic and 11 clinics (65%) keep the referral guidelines, namely: Oshigambo, Ontananga, Lombardt, Olukonda, Omuthiya, Shanamutango, Farm Scott, Okankolo, Onyuulae, Onamishu and Onkumbula.

Fourteen (82%) facilities (Oshigambo, Tsumeb, Ontananga, Lombardt, Olukonda, Onkumbula, Onayena, Ndamona, Omuthiya, Shanamutango, Farm Scott, Okankolo, Onyuulae and Onamishu) use referral forms and 9 (53%) facilities (Oshigambo, Olukonda, Onayena, Lombardt, Ndamona, Tsumeb, Okankolo, Onamishu and Onkumbula) accurately completed the referral forms

Ten (59%) facilities (Oshigambo, Ontananga, Olukonda, Onayena, Omuthiya, Shanamutango, Tsumeb, Okankolo, Onyuulae and Onamishu) make use of referral register and 2 (12%) facilities (Oshigambo and Olukonda) are accurately completing the referral register.

Seven (41%) facilities (Oshigambo, Ontananga, Olukonda, Ndamona, Tsumeb, Onyuulae and Onkumbula) have a referral focal person, 5 (29%) facilities (Oshigambo, Ontananga, Olukonda, Onyaanya and Onyuulae) have a platform for data review and 4 (24%) facilities (Oshigambo, Ontananga, Olukonda and Onyuulae) use data to identify gaps and plan for interventions, while 4 (24%) facilities (Oshigambo, Ontananga, Shanamutango and Onyuulae) took action based on reviewed data.

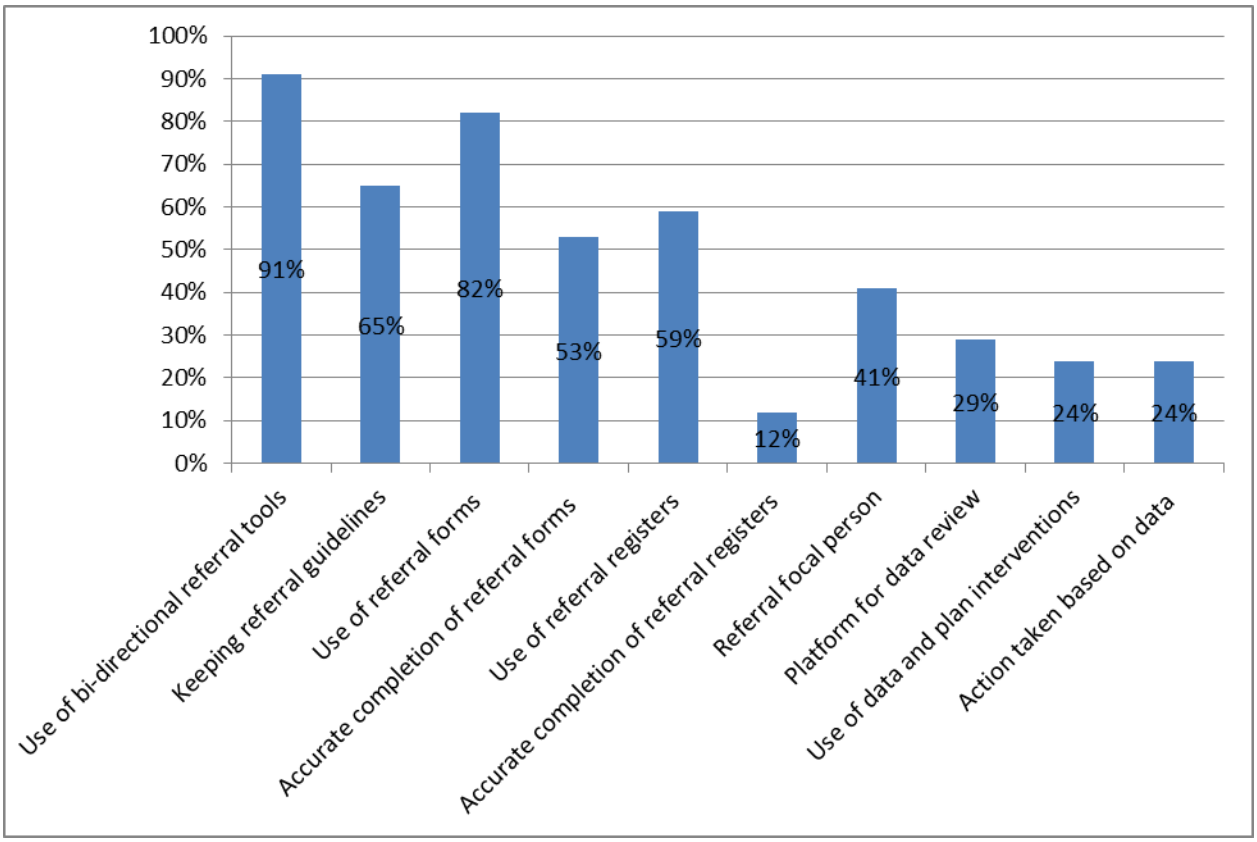

Figure 7: Oshikoto region performance

7.4 Kavango region

Seven (50%) facilities/organization (Rundu CDC, Rundu New Start, Andara Hospital, Nyangana Hopsital, Sauyemwa Clinic, Tondoro H/C, and Katere Clinic) use the B-D referral system tools, while 9 (64%) facilities /organization (Rundu Clinic, Rundu CDC, Rundu New Start, Andara Hospital, Karukuta clinic, Sauyemwa Clinic, Tondoro H/C, Mabuse clinic and Katere Clinic) are keeping referral guidelines**.**

Seven (50%) facilities/organization (Rundu CDC, Rundu New Start, Andara Hospital, Nyangana Hopsital, Sauyemwa Clinic, Tondoro H/C and Katere Clinic) are using the referral forms, of which 3 (43%) facilities (Rundu CDC, Nyangana hospital and Sawyemwa clinic) are accurately using the referral forms.

Six (43%) facilities/organization (Rundu CDC, Rundu New Start, Andara Hospital, Nyangana Hopsital, Sauyemwa Clinic and Katere Clinic) are using the referral registers, of which one (17%) is accurately using them.

Four (28%) facilities/organization (Rundu CDC, Rundu New Start, Andara Hospital, and Katere Clinic) are having a referral focal person, 2 (14%) facilities/organization (Rundu New Start, Andara Hospital) are having a platform for data review and used data to identify gaps and planned interventions

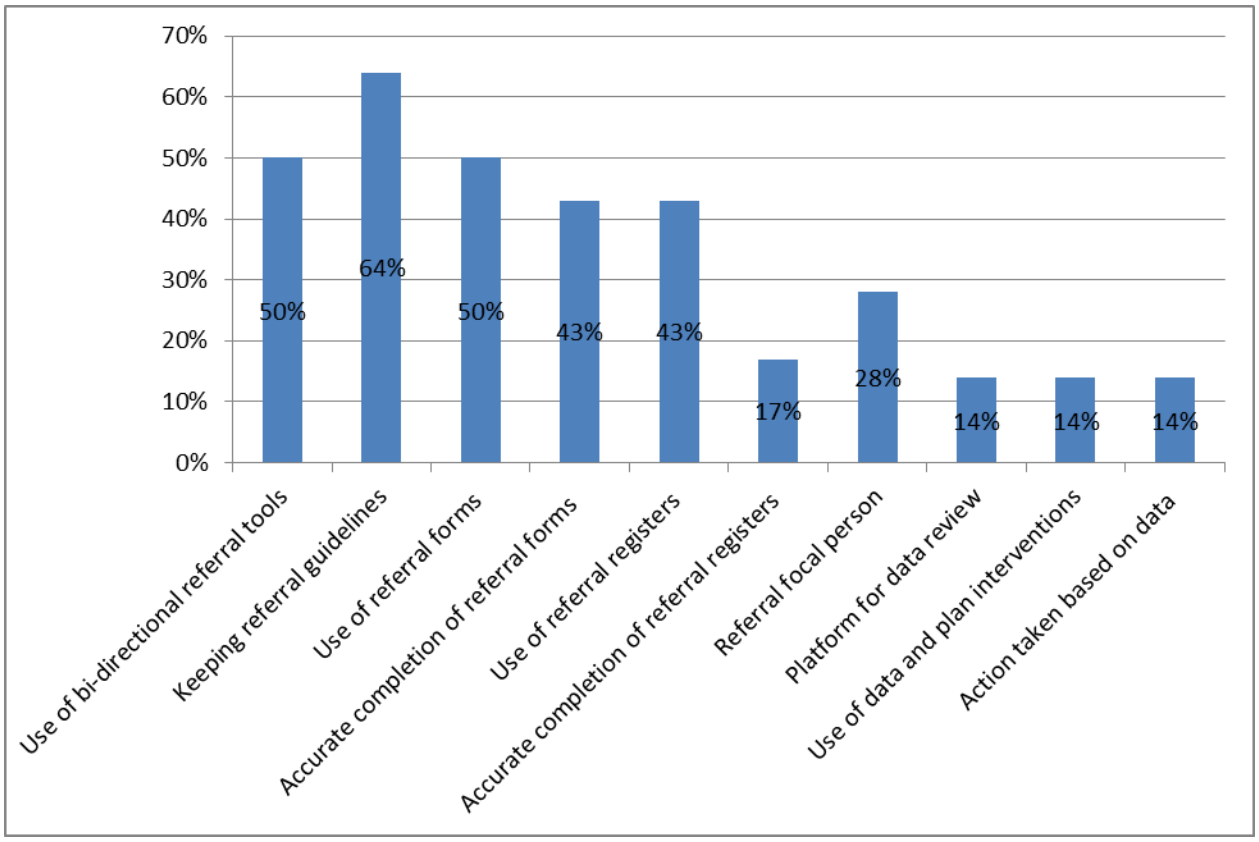

Figure 8: Kavango region performance

8. Best Practices-Lessons Learned

Some facilities created some referral documenting records to ensure that clients that are referred for other services other than HIV are documented, this have been very useful and evident in most facilities, especially when they run out of referral form books and registers**.**

Facilities which were not part of the pilot phase received also some referrals and did not understand it, thus they could not act upon them effectively and efficiently. It is important to roll out the bi-directional referral for common understanding.

To have adequate tools when running a pilot of this nature so that the documentation of clients that are referred elsewhere for referrals are provided with all the required paperwork from facility to facility, because in most situations this has been interrupted by inadequate referral tools which filled up without being replenished timely by the piloting agencies.

9. Challenges

Decreasing donor support while rolling out the BD Referral system may impact the sustainability of the program.

The standardized referral system felt by some overwhelmed clinical staff as creating additional paperwork.

The shortage of bi-directional referral tools in the piloted sites made it difficult to continue referring patients/clients.

10. Conclusion

The bi-direction referral system tools have shown to be useful to ensure continuum of care in most facilities piloted. The system is very useful and had facilitated the follow-up of patients should a feedback not received within the expected period. However, tracing of clients/patients was a challenge; only 4 facilities managed well this process. It is important to reinforce on the gaps identified in the respective sites and roll out the system.

11 Recommendations

1. The MoHSS in collaboration with IntraHealth to roll out the bi-directional referral system by March 2013
2. The MoHSS in collaboration with IntraHealth to organize a TOT for the bi-directional referral system in order to have trainers in all the 13 regions, by February 2013.
3. The MoHSS to strengthen the chain supply management in order to avoid stock out of the B-D referral tools.
4. The facilities to close all identified gaps

References

MOHSS/DSP, Government of Namibia (2009*). Palliative Care Situation Analysis*. Ministry of Health and Social Services-Directorate of Special Programmes. Windhoek (Namibia)

MOHSS/PHC, Government of Namibia (2009). *Draft National Guidelines on Referrals.* Ministry of Health and Social Services-Primary Health Care. Windhoek (Namibia)

MSH (2010). *Patient Mobility Study*. Management Sciences for Health. Windhoek (Namibia)

Annexes

Annex 1: Data Collection Tools

Final Assessment of the bi-directional referral Network tools: Khomas, Kavango, Oshikoto and Oshana Regions 25 July - 10 August 2012						
1. Standard	**Verification Criteria**	**Rating**				**Comments**
	Observe:	**0**	**1**	**2**	**N/A**	
1.1 Availability and accuracy of Referral tools	Does the facility use the bi-directional referral tools? If 0 proceed to no. 4 (action plan matrix)					
	Does the facility keep the referral guidelines					
	Does the facility use the referral forms					
	Are referral forms accurately completed					
	Does the facility use the referral register					
	Is the register accurately completed					
	Does the facility use the referral monthly summary report form					
	Are the monthly report form accurately completed					
	Does the facility compile the information from the registers					

1.2 Efficacy use of data	Does the facility have Platform for data review					
	Data used to identify gaps and plan intervention					
	Action taken based on reviewed data					
2. Experience on the use of the bi-directional referral Tools	**Comments/Challenges:**				**Recommendations:**	
3. Summary						
Total of criteria	12	Total marks	20/24			
Total obseved		Total achieved				
4. Action Plan Matrix						
Performance Gaps	Selected interventions	Responsible person	Time line			
5. Details of interviewed person						
Name and surname	Title	Contact details	Signature			
6. Details of official conducting the interview						
Name and surname	Title	Contact details	Signature			
END						

0 = no criteria in place

1 = criteria not fully implemented

2 = criteria fully implemented

Skip shaded areas

Annex 2: Facility visited and People Met

Oshana Region

Facility	**People met**	**Title**
IHO – PHC*	Ms. A. Primus	PRN
Ou Nick HC	Ms. F. Moses	PRN
Okatana HC	Ms. Ifugenia Nuuyoma	SRN
Ongwediva HC	Ms. S. P. Chirodzen	RN
Uukwiyuushona*	Ms. M. K. Kalumbu	RN
Eheke Clinic	Ms. Iita Shoopala	RN
Ehafo Clinc	Ms. J. Emvula	RN
Enkono Clinic	Mr. P. Shalyomunhu	EN
Ombundja Clinic	Mr. L. Shigwedha	EN
Okaukasheshe*	Ms. H. Ashivudhi	EN
Ekamba Clinic	Ms. H. Shigwedha	RN
Okaku Clinic	Ms. Ileni N. Shipanga	RN
Onamutayi Clinic	Ms. P. Iyambo	SRN
Ondangwa Clinic	Ms. S. Musariri	RN
Eluwa Clinic	Ms. K. Johannes	RN

***USED THE REFERRAL SYSTEM EFFECTIVELY AND ACCURATELY**

Oshikoto Region

Facility	People met	Title
Tsumeb CDC	Siphilisikle Ndlovu	RN
Oshigambo Clinic*	M. Kapewasha	RN
Omuthiya Clinic	N. Mpadhi	RN
Onayena Clinic	K. Ihambo	PRN
Onyulae Clinic	Aune M. Uugwanga	RN
Okankolo HC	Cecilia Nghidimondjila	RN
Olukonda Clinic	Maria Iyambo	EN
Lombard Clinic	Ms. Hausiku Katarina	CC
Shanamutango Clinic	M. Namuhuya	SCC
Farm Scott	Bonifatius Shuuveni	R/N/A
Onamishu	C.K. Imbili	EN
Onkumbula Clinic	Sipopra Mupofi	EN
Tsintsabis Clinic	Thikusho Andreas-M	EN
Ontananga Clinic*	Helena N .Kadhikwa	RN
Ndamono Clinic	Rachel Samuel	RN

*** USED THE REFERRAL SYSTEM EFFECTIVELY AND ACCURATELY**

Kavango Region

Facility	People met	Title
Sampyu Clinic	Katota Walter	E/N
Katere Clinic	Veronica Mpande	RN
Nkarapamwe Clinic	Haufiku Agnes	E/N
Nankudu CDC	Sobby Muyakui	R/N
Mupini HC	Mrs.Shautam O.	R/N
Bunya HC	Zulu Right Well	R/N
Tondoro HC	Siremo Alfons	R/N
Nkurenkuru HC	Ndadi Reino	PR/N
Nyangana	Caltas Wakatama	RN
Andara	J. Zunguzwa	RN
Kayengona	Wilhelmina Simon	EN
Kaisosi	Cesar Dilia	EN
Karukuta Clinic	Shampari Paulina Kapande	RNM
Sauyemwa Clinic	Elizabeth Kinoti	RN
Rundu Clinic	Leopoldine Mutero	PRN

VCT RUNDU; USED THE REFERRAL SYSTEM EFFECTIVELY AND ACCURATELY

Khomas Region

Facility	Person met	Title
Khomasdal HC	Eggesta Mapfuranewe	RN
Dordabis Clinic	Ruben Ilonga	PRN
Okuryongave Clinic	U. Vitals	PRN
Robert Mugambe Clinic	Maria M. Shilongo	CC
Otjomuise Clinic	Carolina Teixeira	RN
Katutura HC	H.S. Natanael	RN
Katutura ANC	Even-Maria Ndjalo	Rn
Katutura ARV Clinic	L. Nyatondo	RN
Rundu New Start	Magdalena Ndora	SCC

TCE

Facility	Person met	Title
TCE Kavango	Emilia Kameya	Deputy Project Manager
TCE Oshana	Annastasia Tizora	M&E Focal Person

Annex 3: Visiting team

Visiting team

Name	Title and Organization	Contact details
Ms. W. M. Kafitha	SHPA/OIs&PC Program,DSP	0811299310
Mr. J. Eino	SHPA/SP, IHO, District	0811470620
Ms. Agatha-Kuthedze	VCT-TA, IntraHealth	0812983608
Ms. Lydia	VCT-regional coordinator-North-East, IntraHealth	
Dr. Alexis Ntumba	Care and Treatment-TA, IntraHealth	0813098815
Mr. Salomo Natanael	ART & PMTCT Coordinator	0812450524